

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-010677

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 46 Primary Registration District No. 4064 Registrar's No. 6

VS 300  
Rev. 4/59

1 0130

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE/AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Caldwell</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kidder</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Caldwell</u> c. CITY OR TOWN <u>Kidder</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Freda Belle Shaw</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 19, 1963</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 8, 1897-65</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	
<b>11. BIRTHPLACE</b> (City and state or country) <u>Macon Co., Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>William Embleton</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Martha Kauffman</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Sterling Shaw</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Sterling Shaw</u> Address <u>Kidder, Mo.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Kidder Caldwell Mo.</u>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Kidder Caldwell Mo.</u>	
<b>21. I attended the deceased from</b> <u>1950</u> to <u>3-19-63</u> and last saw her alive on <u>3-19-63</u> Death occurred at <u>4 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <u>Frank R. D.aley MD</u>		<b>22b. ADDRESS</b> <u>Hamilton, Mo.</u>	
<b>22c. DATE SIGNED</b> <u>3-20-63</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	
<b>23b. DATE</b> <u>3/22/1963</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Kidder Cemetery</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kidder Mo.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Bram Funeral Home Hamilton, Mo.</u>	
<b>25. DATE RECD. BY LOCAL REG.</b> <u>Mar-23-63</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Gladys Jones</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Billie C. Gonder

Licensed Embalmer No. 4980  
P. O. Address Hamilton, Mo.

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.